CHAPTER 32

SENIOR OFFICERS LEGAL ORIENTATION

MEDICAL/LEGAL ISSUES

Outline of Instruction

I. Introduction.

II. The Physical Disability Evaluation System

A. References.

1. DoD Dir 1332.18, Separation or Retirement for Physical Disability (4 November 1996).

2. AR 40-501, Standards of Medical Fitness (12 May 2004).

3. AR 600-60, Physical Performance Evaluation System (25 June 2002).

4. AR 40-400, Patient Administration (12 March 2001).

5. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation (1 September 1990).

B. General.

1. Purpose.

a) Personnel management.

(1) Effective and fit military.

(2) Quality retention.

b) Provide full and fair hearing.

(1) To determine soldier's physical fitness for continued military service.

(2) Determine the level and type of compensation the soldier is due.

(3) Take action to separate or retire the soldier when his or her career is interrupted due to physical disability.

2. Proponent. The proponent for the U.S. Army Physical Disability Evaluation System (PDES) is the U.S. Army Physical Disability Agency (USAPDA), FGS-WRAMC, Washington DC 20307-5001.

a) Commanded by The Adjutant General of the Army, a brigadier general billet.

b) The Deputy Commander, USAPDA, runs day-to-day operations. Normally a line Colonel.

c) Maintains a file copy of individual case processing for five years and a computer database of disability processing back to fiscal year 1981.

C. The Physical Performance Evaluation System (*i.e.* MMRBs) and the Physical Disability Evaluation System (*i.e.*, the MEB and PEB).

1. The MOS Medical Retention Board (MMRB). Aligned with the Physical Performance Evaluation System (PPES), this is an administrative screening conducted by the soldier's command to evaluate the ability of soldiers with P3 or P4 profiles to physically perform their PMOS in a worldwide field environment. The PPES uses the MMRB as an administrative screening board to make this determination.

2. Medical Evaluation Board (MEB). Part of the Physical Disability Evaluation System (PDES), this is a board conducted by the medical treatment facility – after a soldier has received maximum benefit of medical treatment for a condition that may render him unfit for further service – to determine whether the soldier meets AR 40-501's medical retention standards. Soldiers found not to meet these standards are referred to a Physical Evaluation Board (PEB) to determine physical fitness under the procedures of AR 635-40.

3. Physical Evaluation Board (PEB). Also part of the PDES, PEBs are boards that determine fitness or unfitness for duty, and further determine whether soldiers are eligible for disability benefits. It normally is composed of at least two field grade officers and a physician. A Judge Advocate is assigned to represent soldiers at PEBs.

D. MMRB. *See* AR 600-60*, Physical Performance Evaluation System*.

1. The Physical Performance Evaluation System evaluates soldiers issued a "P3" or "P4" profile, to determine if they have the ability to perform in their PMOS. The MMRB is the administrative screening board, at the installation level, that makes this determination.

2. Required Referrals. Soldiers with a P3 or P4 profile must be referred to a MMRB, unless direct referral to a PEB is required, because the soldier's underlying medical condition fails to meet medical retention standards. AR 600-60, para 2-2. Soldiers also must be referred to a MMRB, IAW para 2-2, if, after being retained by a MMRB or found fit by the PDES (MEB or PEB), one of the following events occurs:

a) Soldier receives another P3 or P4 in another profile factor.

b) The conditions for which the soldier previously was retained deteriorate, or the soldier receives additional duty limitations.

c) The commander thinks the soldier is incapable of performing PMOS duties after an appropriate period has passed from the last MMRB or PDES decision (**120 days is recommended**).

3. Soldiers will NOT be referred to a MMRB, IAW para 2-3, if:

a) Their underlying condition does not meet AR 40-501's medical retention standards (they go straight into the PDES or, if they are RC soldiers, are processed for medical disqualification). **Note**: When issuing a P3 or P4 profile, medical officers should determine whether the soldier meets medical retention standards, especially where the profile includes limitations on:

(1) Taking the APFT

(2) Wearing a protective mask

(3) Wearing the ballistic helmet

(4) Firing an individual weapon

(5) Wearing load carrying equipment

For Commanders: Question overly restrictive profiles!! Request reconsideration of the profile, IAW AR 40-501, para 7-8, or refer the soldier for a fitness for duty medical examination, IAW AR 600-20, chapter 5.

b) When their profiles are temporary.

c) When the permanent profile is "1" or "2."

d) When the PDES (MEB and/or PEB) determined them fit for duty (unless an "appropriate period of time", IAW AR 600-60, paragraph 2-2b(3) has passed, and the commander thinks the soldier is incapable of performing PMOS, branch or specialty duties).

4. Referral Time Limits. Active Duty soldiers will appear before an MMRB within **60 days** from the date that the permanent profile is signed. AR 600-60, para 2-4. USAR TPU and ARNG drilling unit soldiers will be referred within 120 days.

5. Processing Time Limits. The MMRB Convening Authority (a General Court-Martial Convening Authority) must make a determination on MMRB recommendations **NLT 30 days** from the date the MMRB adjourned, IAW para 2-4. These General Officers may delegate in writing the approval of MMRB findings and recommendations to the soldier's Special Court-Martial Convening Authority. *See* para 4-6.

6. Training, Deployability and Reassignment Issues.

   a) Training: Soldiers pending a MMRB or final decision on the MMRB recommendation are subject to TDY and field duty, with consideration given to the duty limits recommended by the profile. AR 600-60, para 3-4.

   b) Deployability. Soldiers are nondeployable effective the date their P3 or P4 profile is approved, until the MMRBCA retains the soldier, the Physical Disability Evaluation System finds the soldier fit, or – in the case of RC soldiers – PERSCOM approves an MMRBCA's recommendation for reclassification. AR 600-60, para 3-2.

   c) Reassignment. Soldiers receiving a P3 or P4 profile after receiving assignment orders must appear before the MMRB before proceeding on reassignment. Requests for deferment or deletion must be forwarded to PERSCOM when the MMRB recommends probation, reclassification or referral to the PDES. The only exception is for OCONUS soldiers, whose normal reassignment back to CONUS is not affected. AR 600-60, para 3-6.

7. Reenlistment/Career Status. AR 600-60, para 3-7.

   a) Enlisted soldiers pending MMRB action and determinations may not reenlist, but – if otherwise qualified – may extend their current enlistments IAW AR 601-280 (Active Duty) or AR 140-111 (RC soldiers).

   b) If soldiers are retained in their PMOS, reclassified, or fund fit by the PDES, they will not be denied reenlistment or extension on medical grounds.

   c) Officers pending MMRB may apply for and be considered for CVI, VI, or RA status. However, until the MMRB action is complete, they may not execute the RA oath of office.

8. MMRB Structure and Operations.

   a) MMRBCA (*See* AR 600-60, paras 4-4 – 4-6) – A General Court-Martial Convening Authority. **Note:** Soldiers may be evaluated by an MMRB convened by a GCMCA other than their own, IAW coordination between two GCMCAs. MMRBCAs may delegate in writing the approval of MMRB findings and recommendations to the soldier's SPCMCA.

   b) Board Structure (*See* paras 4-8 – 4-9). Five voting members and nonvoting members. Voting Members include: 1) President – O6; 2) Medical Member – Field Grade MC officer; 3) Additional Voting Members (x3). Nonvoting Members include: 1) Personnel Advisor to advise the MMRB – Commissioned Officer, WO, or Senior Personnel NCO; 2) Recorder – Enlisted soldier.

   c) Commander's Statement (*See* para 4-12). The soldier's immediate commander must write an evaluation of the soldier's physical capability, addressing the impact of the profile limitations on the soldier's ability to

perform the full range of PMOS duties. *See* AR 600-60, fig. 4-4, for an example (*Appendix A of this Outline*).

d) Counseling Statement (*See* para 4-12). Enlisted soldiers must be counseled by the unit first sergeant on the impact of an MMRB decision of retention. *See* AR 600-60, fig. 4-3, for an example (*Appendix B of this Outline*).

e) Conduct of the Board. A formal board, but does not require a written transcript. Soldiers MAY have a spokesperson on their behalf, but are not entitled to legal counsel. Soldiers may present facts and call witnesses, but are not required to provide a statement regarding the origin, occurrence or aggravation of their injury or disease.

f) Board Deliberations. Voting in a closed session. A minority report by dissenting board members may be submitted. The board president orally informs the soldier of the results.

g) Soldier Rebuttal. Soldiers may submit a rebuttal in writing within 2 working days following the board's adjournment. **Note:** Soldiers should be encouraged to seek the help of a Legal Assistance Attorney in preparing their rebuttals.

h) Recommendation – Retention (*See* para 4-17). When a soldier is retained in PMOS, the summary and decision are filed permanently in the OMPF.

i) Recommendation – Probation (*See* para 4-18). Appropriate when the MMRB finds that the soldier's condition may be improved through treatment. Probationary period cannot exceed 6 months. The MMRB also may recommend interim evaluation during the probationary period. **Note**: Commanders may re-refer the soldier to the MMRB before the probationary period expires, if they believe the soldier's condition has improved or deteriorated to such extent that an earlier reevlauation is warranted.

j) Recommendation – Reclassification or Referral to the PDES (*See* paras 4-19 – 4-20). A written summary must explain the board's rationale, document how the medical condition prevents performance in PMOS, and explain concurrence or nonconcurrence with the commander's evaluation of the soldier's ability to perform. Referral to the PDES for conduct of an MEB and PEB is warranted when the soldier's assignment limits or medical condition prevents performance in the soldier's PMOS.

k) Review of MMRB Recommendations (*See* para 4-21). The MMRBCA must ensure that a member of his or her staff, in the grade of major or higher, or a WO4, reviews the MMRB decision. **Note**: The MMRBCA also may delegate decision authority to the soldier's SPCMCA.

E. The Physical Disability Evaluation System. The PDES is comprised of the MEB and PEB, and any required review by the HQ, US Army Physical Disability Agency. The MMRB is not a part of this process, but is a "feeder" into it.

F. **Medical Evaluation Board**. This is a board conducted by the medical treatment facility – after a soldier has received maximum benefit of medical treatment for a condition that may render him unfit for further service – to determine whether the soldier meets AR 40-501's medical retention standards. Soldiers found not to meet these standards are referred to a Physical Evaluation Board (PEB) to determine physical fitness under the procedures of AR 635-40. For this reason, it is essential that the MEB evaluate thoroughly and report all abnormalities and their impact on fitness for duty.

1. Referrals. Referral may be made by HQDA (when questions arise as to the soldier's ability to perform duties because of physical disability); Commanders of MTFs who treat soldiers; **or Commanders,** when they believe a soldier is unable to perform duties. Command referrals must be in writing, and state the reason for believing the soldier cannot perform duties. **Note:** The DD Form 689 (Individual Sick Slip) may be used for such referral. *See* AR 635-40, para 4-8.

2. Appointing Authorities. MTF Commanders, Commander, USAMEDCOM, and Commander, 18th MEDCOM. (These authorities also are Approval Authorities for all MEBs). AR 40-400, para 7-2.

3. MEB Purpose. MEBs document a soldier's medical status and duty limitations. A decision is made to the soldier's medical qualification for retention, based on the criteria in chapter 3 of AR 40-501, *Standards of Medical Fitness*. If the MEB determines the soldier does not meet retention standards, it will recommend referral to a PEB.

4. Processing. If an approved MMRB refers a case to a MEB, the MEB should be initiated within 30 days. MEB processing normally will not exceed 30 days (beginning on the date of the medical officer's narrative summary, through the date forwarded to the PEB). *See* AR 40-400, para 7-1.

5. Composition. MEBs are comprised of two or more physicians. One must be a senior medical officer with detailed knowledge of directives pertaining to standards of medical fitness. AR 40-400 recommends that the physician use the VA Physician's Guide for Disability Evaluation Examinations to describe the nature and degree of the soldier's condition.

6. Proceedings. MEBs operate informally, and review clinical, health and other records. If appropriate, the patient may receive the opportunity to appear in person and present his or her views.

7. Recording MEB Proceedings. MEB proceedings are recorded on DA Form 3947. They will include a brief clinical history by the patient's attending physician. AR 40-400, para 7-7.

8. MEB Approval Authority (*See* AR 40-400, para 7-12). The Appointing Authority (*e.g.*, the MTF Commander) is also the Approval Authority. If the Approval Authority does not agree with the MEB findings, he or she will return the packet to the MEB for further consideration. If, upon further examination, the Approval Authority still does not agree with the Board, he will forward the case to the Regional Medical Command commander for final decision.

9. Counseling Soldiers (*See* AR 40-400, para 7-17). Upon approval of the MEB, the soldier will be counseled about the findings (The Physical Evaluation Board Liaison Officer – a member of the MTF – will provide the counseling). Soldiers have 3 working days to appeal in writing. **Note:** Soldiers should consult a Legal Assistance Attorney to review this documentation and formulate a response. **Commander's Note:** Soldiers may provide additional information – from the unit commander, supervisors, etc. – for forwarding to the Physical Evaluation Board.

10. Referrals to PEBs. MEBS will refer to a PEB those soldiers who do not meet physical retention standards.

11. Expeditious Discharge (*See* AR 40-400, para 7-11). Soldiers identified within the first 180 days as not meeting medical procurement standards may be separated without referral to a PEB. Soldiers found to have a preexisting condition that is not service aggravated may be separated without evaluation by a PEB, if the soldier requests waiver of the PEB.

G. Physical Evaluation Boards. Soldiers who fail to meet retention standards as detailed in AR 40-501, chapter 3, will be referred to a PEB.

1. Board Composition (*See* AR 635-40, para 4-17). Two field grade officers and a physician. The non-physician board members are normally combat arms, and the board's President is a Colonel.

2. Informal Phase (*See* AR 635-40, para 4-20). During the informal phase, the PEB reviews documents, without input from the soldier or his or her legal counsel. The PEB makes its decision based strictly on the soldier's medical and personnel records. Voting does not need to be unanimous. If the results of the informal board satisfy the soldier, the case ends. However, if the results of the informal board do not satisfy the soldier, he may nonconcur and offer no rebuttal; nonconcur with a written rebuttal (and waive appearance before a formal board); or nonconcur and request a formal board.

3. Formal Phase (*See* AR 635-40, para 4-21). The soldier receives military legal counsel, or may retain civilian counsel at his or her own expense. "Appearance" may be in person or via videoteleconference. The soldier may present witnesses, ask questions of the board, and scrutinize evidence. The board's decision does not need to be unanimous.

4. Determination of Not Fit. If the PEB determines that a soldier is no longer fit for duty, and further determines the soldier is eligible for disability benefits, the PEB rates the severity and extent of the disability.

5. Soldier Rebuttal. Following the formal board, the soldier has ten days to submit a written rebuttal. If the rebuttal is denied, the US Army Physical Disability Agency automatically reviews the case. The USAPDA can revise the finding of a PEB by reducing or increasing a rating

6. Presumption of fitness**.** Notwithstanding the standard of fitness given above, when a soldier applies for length of service retirement, is within nine months of mandatory retirement, or has been approved for certain separation actions, or is

referred for physical disability evaluation, the soldier enters the disability system under the presumption that he or she is physically fit. This is known as the Presumption of Fitness Rule.

a) The soldier is presumed fit because he or she has continued to perform military duty up to the point of separation for reasons other than physical disability.

b) The presumption originated in 1973 as a result of congressional dissatisfaction over general officers retiring for physical disability when they were eligible for length of service retirement. It was incorporated into the DoD directive governing military disability evaluation and applies to all soldiers.

c) The philosophy behind the rule is that military disability compensation is for career interruption, not compensation for service-incurred conditions. The latter falls under the purview of the Department of Veterans Affairs.

7. Overcoming the presumption of fitness. Application of the Presumption of Fitness Rule does not mandate a finding of fit. The presumption is overcome if the preponderance of evidence establishes either of the circumstances described below, per DoD Dir 1332.18.

a) The soldier, because of disability, was physically unable to perform adequately the duties of office, grade, rank, or rating. This circumstance is aimed at long-term conditions. Efficiency reports or other performance-related evidence must show the soldier was not reasonably performing the duties of his or her office, rank, grade, or rating. Essentially, the burden of proof is on the soldier to establish unfitness. Ability to perform duties in the future is not an issue under these circumstances.

b) Acute, grave illness or injury, or other deterioration of the soldier's physical condition occurred immediately prior to or coincident with processing for separation or retirement for reasons other than physical disability which rendered the soldier unfit for further duty. Future duty ***is*** a factor in this circumstance.

8. Disposition of Soldiers Undergoing a PEB. *See*AR 635-40, appendix E. MTF commanders who determine a soldier will be processed for a PEB will either decide whether the soldier should be assigned to the medical holding unit of the MTF, whether the soldier will be attached to the medical holding company of the MTF, or process the soldier on an outpatient basis from the parent organization (this occurs whenever possible).

a. Personal Records and Property. Commanders must retain personnel records of soldiers attached to medical holding units, and upon request, furnish the MTF commander (on a "loan" basis) records need to study and evaluate the soldier. Upon receipt of orders reassigning the soldier to a medical holding unit, commanders will forward the soldier's personnel and pay records to the MTF Commander, and forward the soldier's individual clothing.

b. Discharge. *See*AR 635-40, appendix E. After final approval of a PEB case, discharge will be effected usually within 20 days from the date of approval. MTF commanders are responsible for final disposition of soldiers for separation.

9. Rating the disability. Once the PEB has determined the soldier to be unfit, it is required by law to determine the physical disability rating using the Veterans Schedule for Rating Disabilities.

10. Physical disability disposition. Retirement or separation with severance pay is based on the criteria in 10 U.S.C. chap 61.

a) Per 10 U.S.C. chap 61, three factors determine disability disposition:

(1) The rating percentage.

(2) The stability of the disabling condition.

(3) Total active years of federal service.

b) For service-incurred or -aggravated conditions not involving misconduct, the dispositions are described below.

(1) **Permanent disability retirement** occurs if the condition is permanent and stable and rated at a minimum of 30 percent, or if the soldier has 20 years or more of active federal service.

(2) **Temporary disability retirement** occurs if the soldier is entitled to permanent disability retirement except that the disability is not stable for rating purposes. However, stability does not include latent impairment – what happens in the future. If placed on the TDRL, the soldier is required to undergo a periodic medical reexamination within 18 months followed by PEB evaluation. The soldier may be retained on the TDRL or until final determination is made. While the law provides for a maximum tenure on the TDRL of five years, there is no entitlement be retained on the TDRL fall all five years if one's condition improves.

(3) **Continued on active duty (COAD).** To be considered for COAD, a soldier must be found unfit by a PEB because of a disability that was not the result of intentional misconduct or willful neglect, or incurred during a period of unauthorized absence; capable of maintaining himself or herself in a normal military environment without adversely affecting his or hear health or the health of others, and without undue loss of time from duty due to medical treatment; and physically capable of performing useful duty in an MOS for which he or she is qualified or trainable. Additionally, the soldier must have 15, but less than 20 years of total service; or be qualified in a critical skill or shortage MOS; or be disabled de to combat.

III. DOD HIV/AIDS POLICY

A. References.

1. DoD Directive 6485.1, Human Immunodeficiency Virus-1 (HIV-1), 19 March 1991.

2. Army Regulation 600-110, Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV) (1 June 1996).

3. Air Force Instruction 48-135, Human Immunodeficiency Virus Program (1 August 2000).

4. SECNAV Instruction 5300.30C, Management Of Human Immunodeficiency Virus-1 (Hiv-1) Infection In The Navy And Marine Corps (14 March 90); 12792.4, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome in the Department of the Navy Civilian Workforce (12 January 1989).

5. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 1997; Vol. 9, No.1. (Copies of the HIV/AIDS Surveillance Report are available free from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone 1-800-458-5231 or 1-301-519-0023.)

B. The Disease.

1. In General.

2. Disease Progression.

3. Detection.

4. Transmission.

5. Classifications. DODD 6485.1, E2.2; AR 600-110, para. 2-1b. See also Appendix A, this outline.

C. DOD and Service Policies.

1. Accession Testing. HIV positive personnel are not eligible for enlistment or appointment in the military, both Active and Reserve Component. DODD 6485.1, para. 4.1; AR 600-110, para. 1-14a.

   a) HIV screening for enlisted applicants is conducted at Military Entrance Processing Stations (MEPS). DODD 6485.1, para. 4.2; AR 600-110, para. 3-3b.

   b) Officer applicants are screened during pre-contracting, pre-scholarship, or pre-appointment physical examinations. DODD 6485.1, E5; AR 600-110, para. 3-3h.

(1) U.S. Military Academy cadets, midshipmen and persons attending the Uniformed Services University of Health Sciences are separated and discharged with an honorable discharge if HIV positivity is the sole basis for discharge. The Superintendent may delay separation until the end of the current academic year or allow graduation in final year. DODD 6485.1, para. E5.1.3; AR 600-110, para. 3-3h(1).

(2) ROTC cadets are disenrolled at the end of the academic term in which the HIV infection is confirmed. No recoupment action is initiated. DODD 6485.1, para. E5.1.2; AR 600-110, para. 3-3h(2).

(3) OCS candidates who are in their initial entry training are disenrolled from the program and discharged with an honorable or entry level separation, as appropriate. DODD 6485.1, para. E5.1.1; AR 600-110, para. 3-3h(3).

(4) OCS candidates who have completed entry level training are disenrolled, reassigned in their original enlisted specialty and administered in accordance with Service regulations for enlisted personnel. DODD 6485.1, para. E5.1.1 AR 600-110, para. 3-3h(3).

(5) No waiver for HIV infection is authorized.

(6) All personnel disenrolled from officer programs who are separated shall be given preventive medicine counseling and advised to seek civilian treatment.

c) Prior service personnel required to meet accession medical fitness standards must have a negative HIV test no more than 6 months before enlistment in the Selected Reserves. Active duty soldiers transferring to or enlisting in the Selected Reserves without a break in service must have a negative HIV test within the preceding 24 months. AR 600-110, para. 3-3g.

2. Disease Surveillance.

a) DOD Policy (DODD 6485.1, para. E6.2) requires periodic testing with the following priority for military personnel:

(1) Deployed or deploying to high HIV risk area,

(2) Permanent assignment overseas,

(3) Temporary deployment overseas,

(4) Specific categories (medical personnel, drug and alcohol rehab, prenatal patients) per service regulation, and,

(5) All remaining personnel per service regulation.

b) Army. Active duty and Reserve Component soldiers are periodically screened for evidence of HIV infection.

(1) All active duty soldiers are tested routinely at least biennially. AR 600-110, paras. 2-2h and 2-7. Testing is keyed to birth month screening. AR 600-110, para. 2-7b.

(2) Active duty and Reserve Component soldiers who PCS to overseas (defined as outside the 50 states, Puerto Rico, and the District of Columbia) must have a negative HIV test within the 6 months prior to their portcall. AR 600-110, paras. 2-2k and 2-7e.

(3) Active duty soldiers who are scheduled for overseas TDY or deployment that will not exceed 179 days must have a negative HIV test within the 24 months prior to the departure date. AR 600-110, para. 2-2k(1).

(4) Active duty personnel scheduled for overseas TDY or deployment exceeding 179 days must have a negative HIV test within the 6 months prior to departure date. AR 600-110, para. 2-2k(2).

(5) Reserve Component soldiers are tested every 5 years. Reserve Component soldiers may also receive testing during their periodic physicals. AR 600-110, paras. 2-2i and 2-8.

(6) Reserve Component personnel scheduled for overseas duty: Less than 30 days - 24 months prior to departure date. Greater than 30 days - 6 months prior to their reporting date. AR 600-110, para. 2-2k(3).

c) Family members and other health care beneficiaries are not required to have an HIV test. However, DA policy is to routinely inform patients that physicians will order any necessary clinically indicated tests, to include HIV, unless the patient specifically declines such tests. DODD 6485.1, para. E6.2.5. Generally, HIV testing is "clinically indicated" under the circumstances listed below:

(1) All blood donors;

(2) All patients with suspicious illnesses;

(3) All persons admitted to Army hospitals unless tested during the proceeding twelve months;

(4) All persons seen at sexually transmitted disease clinics;

(5) Certain blood recipients;

(6) Sexual partners of HIV-infected individuals;

(7) All pregnant women at the time of their initial prenatal evaluation and at time of delivery, if the mother is identified as being at high risk;

(8) All persons enrolled in alcohol and drug rehabilitation programs (Tracks II or III);

(9) Adults undergoing physical examinations;

(10) All persons presenting at emergency rooms with evidence of trauma, such as shootings, stabbings, IV drug use, and rape;

(11) All persons with acute or chronic hepatitis B infection; and

(12) All persons who are dead on arrival or who die in emergency rooms.

d) DOD Civilians.

(1) Civilian employees and applicants for employment may not be mandatorily tested for HIV except to comply with valid host nation laws. DODD 6485.1, para. 6.10.

(2) HIV-positive civilian employees are treated no differently than other employees. They are permitted to work as long as their performance is acceptable and they do not pose a significant safety or health threat to themselves or others. They are considered handicapped employees within the meaning of the Rehabilitation Act of 1973 and are entitled to a reasonable accommodation if otherwise qualified. AR 600-110, paras. 1-14k, l, and m.

3. Health Education. DODD 6485.1, para. E6.3.

a) Upon identification, military health authorities will counsel the individual and others at risk regarding:

(1) Significance of a positive antibody test;

(2) Mode of transmission of the virus;

(3) Appropriate precautions, personal hygiene, and measures required to minimize transmission;

(4) Need to advise any past and future sexual partners of their infection;

(5) That they are ineligible to donate blood, organs, or semen;

(6) To always use condoms (except with a spouse who is fully informed of the soldier's condition).

(7) Counseling is recorded on DA Form 5669-R. Commanders will receive a copy of this form. AR 600-110, para. 2-14d.

(8) Soldiers who violate the preventative medicine counseling are subject to administrative separation. AR 600-110, paras. 4-12e and 4-13c.

b) The medical assessment of each exposure to or case of HIV infection includes an epidemiological assessment (EPI) of the potential transmission of HIV to other persons. AR 600-110, para. 7-3.

c) Commander's Counseling. AR 600-110, para. 2-14.

(1) Commanders formally counsel soldiers who test positive for the HIV antibody immediately after the post-diagnosis preventive medicine counseling. Commander counseling includes:

(a) A direct order to verbally advise all sexual partners of their infection prior to engaging in intimate sexual behavior or other behavior involving a significant risk of HIV transmission (such as behavior that would result in the exchange of blood or seminal fluid between persons);

(b) A direct order to use condoms when engaging in sexual relations (including, but not limited to, sexual intercourse, oral-genital, or anal-genital contact) with persons other than their spouse or with their spouse unless the spouse freely and knowingly consents to such relations after being informed of the soldier's infection (See also AR 600-110, para. 2-13b(9);

(c) A direct order not to donate blood, sperm, tissues, or other organs; and

(d) A direct order to inform all health care workers of their infection when seeking medical or dental treatment.

(2) Commanders record counseling on DA Form 4856 (General Counseling Form) (*Appendix C, this outline*). AR 600-110 includes a reproducible sample form.

(3) Commanders maintain the counseling form in unit personnel files. Upon reassignment, commanders forward the form in a sealed envelope to the gaining commander. AR 600-110, paras. 2-14d and 2-17.

4. Retention.

a) Repeal of 10 Feb 96 statute mandating immediate discharge of HIV-positive service members. Repeal of amendments to 10 U.S.C. § 1177 effective 24 Apr 96.

b) Current Policy.

(1) Active duty personnel with evidence of HIV infection are referred for medical evaluation board to evaluate and document their fitness for continued service regardless of clinical staging. DODD 6485.1, para. 4.3 and E2.4.2

(2) HIV positive service members are managed in the same manner as personnel with other progressive illnesses.

(3) Soldiers meeting medical retention standards may reenlist, if otherwise eligible. AR 600-110, para. 4-5a.

(4) Personnel showing no evidence of clinical illness (generally associated with WR-1 or WR-2 stages) or other indications of immunologic or neurologic impairment related to HIV infection are not separated solely on the basis of HIV positivity. DODD 6485.1, para. 4.3; AR 600-110, para. 1-14d.

(5) Reserve Component soldiers with serologic evidence of HIV infection have 120 days to complete a medical evaluation to determine their fitness for continued reserve service. Reservists found medically fit are permitted to serve in the Selected Reserves in a nondeployable billet, if available. AR 600-110, para. 5-17.

5. Assignment Limitations - Current Policy.

a) HIV-positive service members are not deployed overseas (defined as outside the 50 states, Puerto Rico, and the District of Columbia). DODD 6485.1, para. 6.16; AR 600-110, paras. 1-14e and 4-2a.

b) Soldiers confirmed HIV positive while stationed overseas are reassigned to the United States as soon as possible, regardless of PCS rules. AR 600-110, para. 4-7.

c) HIV-positive soldiers are NOT assigned to:

(1) Any TOE or MTOE unit. AR 600-110, para. 4-2b. Installation commanders may reassign any HIV-infected soldier from such units to TDA units on their installation. AR 600-110, para. 4-2b; or

(2) USAREC, Cadet Command, or ARNG Full Time Recruiting Force if the soldier's medical condition requires frequent follow up and the unit is not near an Army MTF capable of providing such treatment. Commanders must report these soldiers to PERSCOM for assignment instructions. AR 600-110, para. 4-2b(3); or

(3) Military education programs resulting in additional service obligation. AR 600-110, para. 4-2b(2). This limitation does not apply to military schools required for career progression, such as an advanced course or CGSC. See also AR 600-110, para. 4-4.

d) Assignment preclusion from units, programs, organizations, or schools other than those listed in the regulation require HQDA (DAPE-HR) approval. AR 600-110, para. 4-2c.

e) Commanders may not change the assignment of an HIV-infected soldier unless required by the regulation or the soldier's medical condition. AR 600-110, para. 4-2d.

f) Commanders may not group HIV-infected soldiers into the same unit, duty area, or living area unless no other unrestricted units, positions, or accommodations are available. AR 600-110, para. 4-2d.

g) Commissioned officers in DOD sponsored professional education programs are disenrolled from the program at the end of the academic term in which the HIV infection is confirmed. Any additional service obligation incurred by participation in the program is waived. Financial assistance received is not subject to recoupment. AR 600-110, para. 4-2b(2).

h) Family members who are confirmed as HIV positive may accompany their sponsor overseas. The sponsor may request deletion from the overseas assignment based on compassionate reasons or may request an "all others" tour. If the initial diagnosis of a family member occurs while overseas, the sponsor may apply for a compassionate reassignment to the United States. Mandatory PCS of the sponsor will not occur based solely on the HIV positivity of the family member. AR 600-110, para. 4-3 and 6-12.

i) Comply with host nation requirements of HIV screening for DOD civilians. DODD 6485.1, para. 4.10

6. Separation.

a) "Individuals with serological evidence of HIV-1 infection who are fit for duty shall not be retired or separated solely on the basis of …HIV-1 infection." DODD 6485.1, para.4.3

b) Regular and Reserve Component service members who are determined to be unfit for further duty due to progressive clinical illness or immunological deficiency due to HIV infection are processed for separation or retirement. DODD 6485.1, para. 4.5.

(1) Regular Army and Reserve Component commissioned and warrant probationary officers, who are confirmed HIV positive within 180 days of their original appointment or who report for initial entry training in an AD status (other than ADT) and are confirmed HIV positive within 180 days of reporting to AD, are processed for discharge under the provisions of AR 635-100, Chapter 5, section IX (Elimination of Probationary Officers). AR 600-110, para. 4-12d.

(2) Enlisted soldiers, confirmed HIV positive within 180 days of initial entry on AD, are separated for the convenience of the government for failure to meet procurement medical fitness standards under the provisions of AR 635-200, paragraph 5-11. See AR 600-110, para. 4-13b.

(3) HIV-positive military personnel who fail to comply with lawfully ordered preventive medicine procedures, including the commander's "safer sex" order, are subject to appropriate administrative and disciplinary actions, including separation. AR 600-110, paras. 4-12e, 4-13c, and 2-14c.

(4) HIV-positive military personnel may request separation from the service for the convenience of the government. AR 600-110, paras. 4-12a, b, and 4-13a, b.

7. Limited Use Policy.

a) DOD policy (DODD 6485.1, para. E3) prohibits the use of HIV testing information and information obtained during the EPI as an independent basis for adverse administrative or disciplinary action, except for:

(1) Accession separations;

(2) Voluntary separations;

(3) Armed Service Blood Look Back activities;

(4) Rebuttal or Impeachment purposes consistent with law or regulation;

(5) For administrative or disciplinary actions resulting from disobeying preventative medicine order; and

(6) As an element of proof or aggravation in administrative or criminal action.

b) **Adverse personnel actions** include: court-martial; nonjudicial punishment; line of duty determination; involuntary separation action (other than for medical reasons); administrative or punitive reduction in grade; denial of promotion; a bar to reenlistment; as the basis for an unfavorable entry in a personnel record; as a basis to characterize service or to assign a separation program designator; or in any other action considered an adverse personnel action (*e.g.,* OER or NCO-ER). DODD 6485.1, para. E3.2.1; AR 600-110, para. 7-3b.

c) The limited use policy does <u>not</u> apply to:

(1) The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse or relevant sexual activity (or lack thereof) is first introduced by the soldier.

(2) Disciplinary or other action based on independently derived evidence.

(3) **Nonadverse personnel actions** include such as reassignment; disqualification (temporary or permanent) from a personnel reliability program; denial, suspension, or revocation of a security clearance; suspension or termination of access to classified information; and removal (temporary or permanent) from flight status or other duties requiring a high degree of stability or alertness such as explosive ordnance disposal (a medical evaluation board must determine whether removal from flight status or a similar position is necessary). DODD 6485.1, para. E3.2.3; AR 600-110, para. 4-6.

(4) Any evidence or information derived from sources independent of the epidemiological assessment. AR 600-110, para. 7-4d.

8. Release of Information.

a) HIV data on a soldier is covered by the Privacy Act (5 U.S.C. § 552a).

b) Release is on an internal agency "need to know basis." 5 U.S.C. 552a(b)(1).

c) The service regulations stress the need for extra precautions in protecting HIV records. *See, e.g.*, AR 600-110, paras. 1-12g, 1-13f, 1-14n, and 1-14o(3).

(1) All soldiers are individually and privately notified of all positive HIV test results in a face-to-face interview with a designated physician. AR 600-110, para. 2-12.

(2) Unit commanders will accompany HIV-positive soldiers to the initial notification by medical personnel. Unit commanders will not remain for the EPI. AR 600-110, para. 1-13d.

(3) MEDDAC/MEDCEN will notify commander if HIV-positive soldier requires change in profile status.

d) IAW AR 600-110, para. 2-12f, information concerning an individual's HIV positivity is only released outside DOD in the following circumstances:

(1) Military health care beneficiaries who are determined "at risk" (e.g., spouse of an HIV-positive soldier; See also AR 600-110, para. 6-9) are contacted directly by medical authorities and advised to seek medical evaluation;

(2) Individuals who are not military health care beneficiaries, who are determined "at risk" (e.g., sexual partner of an unmarried HIV-positive soldier), are contacted through the local public health authorities, unless disclosure to the civilian health authorities is itself prohibited by the jurisdiction.

(3) Release of information to local (including host nation) health authorities, concerning the identity of HIV-positive individuals, is done in accordance with the reporting requirements of the local jurisdiction.

e) Spouses of Reserve Component HIV-positive soldiers are notified and offered an opportunity for voluntary HIV testing and counseling. AR 600-110, para. 6-9b.

IV. Other Command-Related Health Issues

A. Mental Health Evaluations of Members of the Armed Forces

1. DoD Directive. DoD Dir. 6490.1, "Mental Health Evaluations Of Members Of The Armed Forces," 1 October 1997.

2. DoD Instruction 6490.4, "Requirements for Mental Health Evaluations Of Members of the Armed Forces," 28 August 1997.

3. Generally. Soldiers have certain rights when referred for a mental health evaluation. The procedures outlined in the DoD Directive and Instruction (above) are designed to ensure Commanders do not use the mental health system for "reprisal" or to control "whistleblowers."

4. The Directive does NOT apply to the following:

   a. Patient self-referrals

   b. Referrals to drug and alcohol rehabilitation programs.

   c. Referrals to mental health professionals for routine evaluations as required by other DA Regulations (*e.g.*, AR 635-200, for administrative separation actions).

   d. Referral for mental health evaluations required for certain duties (*e.g.*, security clearance evaluation or Personnel Reliability Program purposes).

5. Referral Procedures.

   a. Non-Emergency. See *Appendix D* of this outline for the DoD Instruction-approved written notice to the Mental Health Professional, and *Appendix E* for the approved written notice to the soldier.

   b. Emergency. IAW DoD Directive 6490.1, a commanding officer "shall refer a Service member" for an emergency mental health evaluation as soon as practicable whenever the member, by actions or words, such as actual, attempted or threatened violence, intends or is likely to cause serious injury to himself or others and when the facts and circumstances indicate the member's intent to cause such injury is likely, and when the commander believes the member may be suffering from a severe mental disorder.

      (1) Before transporting a service member for an emergency evaluation – or shortly after that, if time and the emergency do not permit – the commander will consult a mental health

care provider or other health care provider at the MTF where the member is being transported, in order to communicate the circumstances and observations about the member that led the commander to think the member's behavior constituted an emergency. The commander must forward a memorandum of the information discussed.

(2) As soon as possible after the referral, the commander must provide the soldier a memorandum such as that contained at pp. 40-42 of this outline.

6. New duty to take precautions against threatened injury.

a. Service member communicates to health care provider an explicit threat to kill or seriously injure an identifiable person, or to destroy property under circumstances likely to lead to serious bodily injury or death, and the service member has the apparent intent and ability to carry out the threat.

b. The responsible health care provider shall make a good faith effort to take precautions against the threatened injury. Such precautions may include, but are not limited to:

(1) Notifying the service member's commanding officer;

(2) Notifying military and/or civilian law enforcement authorities where the threatened injury most likely may occur;

(3) Notifying a potential victim; or

(4) Clinical treatments

c. The provider shall then inform the service member, and document in the medical record, that these precautions have been taken.

B. Immunizations

1. Reference. AR 600-20, *Army Command Policy*, para 5-4 (13 May 2002).

2. Generally. Commanders must ensure that soldiers are educated about the intent and rationale behind routine and theater-specific immunization standards.

3. Dealing with Individuals Refusing to be Immunized.

a. Ensure the soldier understands the purpose of the vaccine.

b. Ensue the soldier is advised of the possibility that the disease may be used as a biological weapon, or naturally present in a possible Area of Operation.

c. Ensure the service member is able to discuss any objections with medical authorities.

d. Counsel the soldier, in writing, about the legal requirement to be vaccinated. The counseling form will state that if the soldier continues to refuse vaccination, he or she will be ordered to receive the vaccine, that failure to do so could result in UCMJ and/or administrative action for failure to obey a lawful order.

e. Order the soldier to receive the vaccination. If the soldier consents to be immunized, adverse action should not normally be taken based solely on the initial declination.

4. Involuntary Immunizations. Not ordered by a commander below the General Court-Martial Convening Authority, unless authority has been delegated. Use only the minimum force needed to assist medical personnel.

V. General Medical Legal Issues Related to Medical Treatment Facilities.

A. Off Duty Employment.

1. References. DOD Directive No. 6025.7, Off-Duty Employment By DOD Health Care Providers (Oct. 21, 1985); Army Reg. 40-1, Medical Services: Composition, Mission, and Functions of the Army Medical Department, para. 1-8 (1 July 1983) (I03, 4 September 1992).

2. Policy.

a) Military health care providers are available to provide patient care services at all times.

b) Commissioned and warrant officers of the AMEDD on active duty and full-time civil service or equivalent personnel (40 hours per week) will not engage in off-duty employment without the written approval of the commanding officer.

c) Interim change 3 to AR 40-1 at para. 1-8b(1) provides that "[o]fficer trainees (in graduate training programs) are prohibited from moonlighting." That includes interns, residents, and fellowship participants.

d) The regulation is more restrictive for individuals who are paid for giving advice or services to civilian practitioners on the diagnosis or treatment of patients not eligible for DOD medical care. Permission for employment of this nature is limited to those officers who are certified by an American Specialty Board or who are recognized by TSG as having achieved an equivalent level of professional ability. See interim change 3 to AR 40-1, para. 1-8e.

3. Limitations.

a) Military Duties Take Priority. Military health care providers must advise off-duty employer that military duties take priority and may require the officer to leave civilian employment without notice and/or fail to report at the scheduled time.

b) No Compensation for Care to DOD beneficiaries. DOD health care provider may not accept compensation, either directly or indirectly, for care rendered to DOD beneficiary.

c) The "16/6/2 Rule." Off-duty employment cannot exceed 16 hours per week; health care provider must have 6 hours rest between off-duty employment and military duties; location of off-duty job cannot exceed 2 hours driving time from place of military duty. Hours and distance limitations do not apply to off-duty employment performed while on leave.

d) Yearly Off-Duty Status Reports. MTF commander must request yearly statement from all DOD health care providers regarding their off-duty employment status. Negative replies are required.

e) Moonlighters Responsible to File Off-Duty Documents. Military health care providers must file application for off-duty employment and supporting documents at the MTF; individuals must notify commander of any changes in their off-duty job prior to the inception of the changes.

f) Moonlighter Responsible for Off-Duty Licensures. AMEDD personnel engaging in civilian employment are responsible for complying with state licensing requirements and with state and federal drug regulations.

g) No Solo Practice. No Physician can engage in solo practice or assume responsibility for a patient on a continuing basis.

h) Civilian Employers Must Acknowledge Limitations in Writing. The employer must acknowledge conditions of employment in writing, accept compensation and availability limitations imposed upon the military officer, and agree not to seek reimbursement from TRICARE/CHAMPUS or from the patient for services provided to a DOD beneficiary by military health care personnel. AR 40-1, (I03), para. 1-8b(5).

B. Dual Compensation Act. 5 U.S.C. § 5536.

1. The Dual Compensation Act prohibits soldiers and DOD civilians from accepting additional Federal pay for performance of "any other service or duty, unless specifically authorized by law."

2. Applies when other service or duty is in some way connected with the official duty performed or is determined to be incompatible with federal service.

   a) An Army physician, moonlighting at a civilian hospital, cannot accept compensation, directly or indirectly, from TRICARE/CHAMPUS, because the physician has a preexisting duty to render care to any TRICARE/ CHAMPUS eligible patient.

   b) If already employed by federal government, you cannot perform services for the same or different federal agency while retaining the original federal government position.

3. Medicare and Medicaid Compensation. Military personnel engaged in off-duty employment may accept Medicare or Medicaid compensation for the treatment of non-DOD patients. See AR 40-1, para. 1-2 (IO3, 4 Sep 92).

C. Expert Witness Testimony.

1. Testifying as an Expert Witness. See AR 27-40, chapter 7.

   a) General rule is that DA personnel cannot provide opinion or expert testimony except for the U.S.

   b) Prohibition applies to former DA personnel when the testimony concerns official information.

   c) DA maintains strict impartiality in private litigation.

2. Individuals seeking expert testimony or the disclosure of official information must submit, at least 14 days before the desired date of production, a specific written request setting forth the nature and relevance of the testimony/information sought. Promptly transmit this request to your SJA.

3. Exception for AMEDD personnel: members of the Army medical department or other qualified specialists may testify in private litigation when testimony concerns "patients they have treated, laboratory tests they have conducted, or other action

they have taken in the course of their military duties," and testimony is "limited to factual matters." Testimony will not extend to "expert or opinion testimony, to hypothetical questions, or to a prognosis." Members of the AMEDD will only provide expert testimony in cases of "exceptional need or unique circumstances." Such testimony requires HQDA special written authorization. AR 27-40, para. 7-10.

4. Witness Fees. All fees tendered to present DA personnel as an expert or opinion witness, to the extent they exceed actual travel, meals, and lodging expenses of the witness, will be remitted to the United States.

D. Lawsuits Involving Alleged Malpractice by Health Care Providers in Overseas Areas. United States v. Smith, 111 S. Ct. 1180 (1991); Schneider v. United States, 27 F.3d 1327 (8th Cir. 1994).

1. The Supreme Court ruled that the Federal Employees Liability Reform and Tort Compensation Act of 1988 (the "Westfall Act") immunizes Government employees from suit even when an FTCA exception (incidents occurring overseas) precludes recovery against the Government. 28 U.S.C. § 2679.

2. The Supreme Court determined language within 28 U.S.C. § 2679(d) confirms that the FTCA is the exclusive mode of recovery.

3. The Court recognized that substitution of the Government would sometimes foreclose a tort plaintiff's recovery. 28 U.S.C. § 2679(d) specifically states that suits proceeding under the FTCA are subject to the "limitations and exceptions" applicable to FTCA actions.

4. Another, older statute also applies to military medical personnel. The Gonzales Act (10 U.S.C. § 1089) functions solely to protect military medical personnel from malpractice liability and does not create rights in favor of malpractice plaintiffs. The Gonzales Act is effectively subsumed by the Westfall Act for purposes of certification, substitution, and immunity.

E. Medical Care Recovery Claims.

1. 10 U.S.C. § 1095 (as amended by Pub. L. No. 101-510, enacted 5 Nov 90; Pub. L. No. 103-160, enacted 30 Nov 93; Pub. L. No. 103-337, enacted 5 Oct 94; and Pub. L. No. 104-106, enacted 10 Feb 96).

2. Expands ability of U.S. to collect from "third party payers" the reasonable costs of "health care services" furnished to dependents and retirees.

3. Allows collections from insurers (no fault and liability--applies to active duty, family members, and retirees in an MTF after 5 November 1990) and from private health insurance and Medicare supplemental insurers (non active-duty beneficiaries).

   a) Installation Claims Office is responsible for asserting claims against automobile insurers.

   b) Medical Facility is responsible for asserting claims against private health benefits insurers and from Medicare supplemental insurers.

4. Allows recovery for "health care services" and not just for "inpatient hospital care."

5. The statute does not allow recovery under workmen's compensation, from non-automobile liability insurers, or from TRICARE/CHAMPUS.

6. If the care was provided in or purchased by a MTF on or after 30 Nov 93, all money recovered under 10 U.S.C. § 1095, or any other legal theory, is deposited directly into the MTF's OMA account.

7. Money recovered under the following is still deposited into the General treasury for:

   a) Care provided in an MTF before 5 Nov 90 (for collections under 10 U.S.C. § 1095 and the Medical Care Recovery Act).

   b) Care provided in an MTF before 30 Nov 93 (for collections under all other theories of liability, i.e., state workers' compensation, nonautomobile liability insurance, homeowner's/renter's insurance, etc.).

   c) Care provided in a civilian hospital.

8. The MTF's annual appropriation is not offset by the amounts recovered under this program. 10 U.S.C. § 1095(g)(1).

9. Impact of DOD TRICARE is yet to be determined.

F. National Practitioner Data Bank.

1. Established by Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152.

2. Effective 1 September 1990 (55 Fed. Reg. 31,239 (1990)). Criteria and Procedures in 54 Fed. Reg. 42,722 (1989) (codified at 45 C.F.R. Part 60 (1990)).

3. Dep't of Health & Human Services is charged with developing and maintaining a data base on:

   a) Malpractice claims resulting in the payment of money in settlement or judgment.

      Note: DOD policy is that health care providers will not be identified unless peer review determines the standard of care was not met.

   b) Information on actions that affect the clinical privileges of physicians.

4. Statute requires reporting of claims from civilian sector; MOU between DOD and HHS covers reporting of military information.

5. Malpractice Payments. AR 40-68, para. 13-5.

   a) Within 7 days of notification by the local MCJA that a monetary award has been granted or denied, the MTF will submit DD Form 2526 (Case Abstract for Malpractice Awards) to Commander, USAMEDCOM.

   b) If the claim is paid, the MTF will provide a copy of the entire case file, to include the updated DD Form 2526, and copies of pertinent portions of the patient's medical treatment record.

   c) If the claim is denied, the MTF will update the DD Form 2526 to close the case. Case file documents will be maintained by the risk manager for a period of 3 years, unless the case is re-opened due to subsequent litigation.

6. Other Reportable Events--Professional Review Actions.

a) Adverse privileging actions of longer than 30 days will be reported after appellate review, commander decision if no appeal, or separation, whichever comes first.

b) Unprofessional Conduct.

(1) HCPs involved in any unprofessional act will be evaluated by the credentials committee and appropriate privileging or practice recommendations will be made to the commander. A DD Form 2499 will be submitted on privileged providers and other nonprivileged HC personnel who are convicted, plead guilty, plead nolo contendre, receive a discharge in lieu of court-martial or a criminal investigation, or a less than honorable discharge for unprofessional conduct. Reporting will occur within 7 days of the date that formal charges were filed, or the date of discharge, whichever comes first. AR 40-68, para. 10-15.

(2) The following is a nonexhaustive list of conduct, IAW AR 40-68, Appendix I, that constitutes unprofessional conduct:

(a) Fraud or misrepresentation in application for clinical privileges;

(b) Commission of a serious misdemeanor or felony;

(c) Being impaired on duty through misuse of alcohol or drugs; and

(d) Fraud under dual compensation laws.

G. Pharmaceutical Company and Outside Agency Gifts.

1. Basic Prohibition of Gifts from Outside Sources. 5 C.F.R. Part 2635, Part B. An employee shall not solicit or accept a gift from a prohibited source.

a) A prohibited source is defined as any person (including any organization more than half of whose members are persons who are):

(1) Seeking official action by the employee's agency;

(2) Doing or seeking to do business with the employee's agency;

(3) Regulated by the employee's agency; or

(4) Substantially affected by the performance of the employee's official duties.

b) Definition of a Gift. The term "gift" includes almost anything of monetary value.

(1) Employee may accept unsolicited gifts with market value of $20 or less per occasion, totaling no more than $50 in a calendar year from any one source (this exception does not permit cash gifts or investment interests);

(2) Employee may accept gift if authorized by specific statute/supplemental agency regulation.

(3) The "No Pizza and Coke Rule." Contractors, vendors, manufacturing representatives, and others seeking business with the AMEDD may visit MEDCOM activities if they agree not to bring in or provide food or beverages at the MEDCOM facility. HSC Memo, 11 Feb 93, SUBJECT: "Gifts and the New Standards of Ethical Conduct."

2. Acceptance of Gifts by the Government--Statutory Implementation.

a) "The Secretary [of the Army] may accept ... any gift ... made on the condition that it be used for the benefit ... of a ... hospital . ..." 10 U.S.C. § 2601.

b) "The Secretary of Defense may accept [any gift] for use by the Department of Defense." 10 U.S.C. § 2608 (1990).

3. Acceptance of Gifts by the Government--Regulatory Implementation.

a) Unconditional gifts. Commanders may accept "unconditional gifts" valued at less than $1,000.00. The regulation does not specify what level of commander may accept the gift. AR 1-100.

(1) If the donor specifies that the gift be used in a certain place, manner, or for a certain purpose, but the condition is for normal use, the gift is to be considered unconditional. AR 1-100, para. 3b(1)(b).

(2) There is no Secretary of the Army delegation of authority to accept conditional gifts. Must staff all gifts of money or equipment to Army hospitals through command channels to the Secretary of the Army for acceptance. DAJA-AL 91/3245 (7 Jan 92).

b) Conditional gifts require Secretary of the Army approval. See AR 1-100.

c) MEDCOM will not accept a gift unless prior approval is obtained from Administrative Services Division (ASD), Office of the Deputy Chief of Staff for Information Management, HQ, Health Service Command. HSC Supp. 1 to AR 1-100, para. 5f. Must submit written evidence of coordination with the servicing SJA and procurement officer. HSC Supp. 1 to AR 1-100, para. 5g. ASD will approve/disapprove or forward to the Secretary of the Army for final decision.

4. Clinical Investigation Program. AR 40-38.

a) May use investigational drugs, devices, biologics, vaccines, or placebos in approved clinical investigation (CI) programs. AR 40-38, para. 3-6(a)(8).

b) Drugs, placebos, biologics, and medical devices not commercially available, and equipment loaned for an approved CI program are not considered gifts and are accepted by MTF or DTF commanders. AR 40-38, para. 3-6b(3)(g).

c) A gift is tendered to a CI program must be made in accordance with AR 1-100. Must provide a receipt and an accounting for every gift. AR 40-38, para. 3-6b(3)(g). The receipt will specify the nature of the gift, its monetary value, requests of the donor, conditions of acceptance, and include a statement that the study is subject to delay or termination if required in the interest of the military mission. AR 40-38, para. 3-6b(8).

5. "School Solution."

a) Do not let physicians dispense "medication samples" that are not on the MTF formulary.

b) Ensure gift acceptance IAW AR 1-100.

H. AMEDD Personnel and AIDS/HIV.

1. Current Policy on Removing Health Care Providers From Patient Care: Must make an individual, case-by-case determination that removal from patient care is required. May not enact blanket policy of removal of all cases or of certain categories of cases. The sole basis for limiting the duties of a soldier infected with HIV is that it is necessary to protect the health and safety of service members. DOD Dir. 6485.1, para. E.18, 19 Mar 91

EXCEPTION: AR 600-110, para. 2-13b(15), states that "HIV infected health care providers with an exudative or weeping dermatitis will be removed from patient care positions until the condition improves."

2. Assignment Limitations.

a) HIV-infected soldiers not deployed or assigned overseas. Soldiers confirmed HIV positive while overseas are reassigned to the U.S. AR 600-110, para. 4-2a.

b) In the U.S. (including Alaska, Hawaii, Puerto Rico), HIV-infected soldiers are not assigned to MTOE/TOE units. Commanders may reassign any HIV-infected soldier from a MTOE/TOE unit after completion of a normal tour of duty. AR 600-110, para. 4-2b(1).

c) HIV-infected soldiers are not assigned to military sponsored educational programs, regardless of length, which would result in an additional service obligation. This includes advanced military or civilian schooling, professional residency, and fellowships. This restriction does not apply to

military schools required for career progression in a soldier's MOS, branch, or functional area (i.e., CGSC). AR 600-110, para. 4-2b(2).

3. Limited Use Policy. Under existing Army regulations, information obtained from the soldier is subject to the following protections

   No adverse action is authorized solely on a positive HIV test or on information derived from an EPI assessment and HIV confirmatory laboratory tests results

4. Duty to warn. 1988 DCSPER message requires preventive medicine physician performing initial notification and health care provider conducting the EPI to explain the limited use policy. DCSPER holds this as current policy, yet requirement not reflected in regulation.

I. Mental Health Evaluations of Members of the Armed Forces

1. DoD Directive. DoD Dir. 6490.1, "Mental Health Evaluations Of Members Of The Armed Forces," 1 October 1997.

2. Referral of Service members for mental health evaluations.

   a) Command referrals.

   b) Protections of the rights of service members against improper referrals for mental health evaluations. (Military Whistleblowing – Boxer amendments).

3. New duty to take precautions against threatened injury.

   a) Service member communicates to health care provider an explicit threat to kill or seriously injure an identifiable person, or to destroy property under circumstances likely to lead to serious bodily injury or death, and the service member has the apparent intent and ability to carry out the threat.

   b) The responsible health care provider shall make a good faith effort to take precautions against the threatened injury. Such precautions may include, but are not limited to:

      (1) Notifying the service member's commanding officer;

      (2) Notifying military and/or civilian law enforcement authorities where the threatened injury most likely may occur;

      (3) Notifying a potential victim; or

      (4) Clinical treatments

   c) The provider shall then inform the service member, and document in the medical record, that these precautions have been taken.

VI. CONCLUSION.

APPENDIX A

[Letterhead]

Office Symbol Date

MEMORANDUM THRU (Chain of Command)

FOR Commander, 99th Infantry Division and Fort Defense, ATTN: President, MMRB, Fort Defense, VA 12345

SUBJECT: Notification of MOS/Medical Retention Board Proceedings

1. Sergeant George R. Sewell, 123-45-6789, 11B20, has been informed that an MMRB will evaluate his ability to perform in PMOS 11B20 based on the limitations imposed by his permanent physical profile. Sergeant Sewell acknowledges notification. The First Sergeant counseled him that retention by the MMRB or a finding of fit by the PEB does not exempt him from meeting the physical requirements required for graduation from NCOES. He understands that failure to meet the physical requirements of NCOES will result in denial of promotion or loss of conditional promotion.

2. Sergeant Sewell has been assigned to this company for approximately 22 months. During this time he was promoted to Sergeant based on his overall performance and potential as a team leader. At no time has the physical impairment limited his duties. I have received numerous reports from his supervisor and have personally observed his performance in a field situation. He proves daily that he can perform all physical tasks required of an infantry team leader, the common tasks of STP 21-1-SMCT, and the physical requirements specified for his MOS in DA Pam 611-21, Table 10. There is no doubt in my mind that Sergeant Sewell can physically perform any time, any place, or under any conditions.

Encl
Soldier's Acknowledgement of Notification
And Counseling

FREDERICK B. FALLON
Captain, IN
Commanding

Figure 4–4. Sample of unit commander's evaluation

APPENDIX B

ACKNOWLEDGMENT OF NOTIFICATION AND COUNSELING

I acknowledge notification of my pending MMRB. I understand that –

a. I am required to appear before the MMRB.

b. Retention by the MOS/Medical Retention Board or by the Physical Disability Evaluation System does not exempt me from meeting the physical requirements for attendance and graduation from NCOES.

c. Attendance at NCOES is a prerequisite for promotion to the grades of E-5 through E-9.

d. If my medical condition precludes me from meeting the graduation requirements for my next level of NCOES, I will not be promoted to the next higher grade, or retain a conditional promotion.

e. Per AR 600-8-19, I am in a nonpromotable status while pending evaluation by the MMRB or the Physical Disability Evaluation System.

SIGNATURE _____ *DATE* _____

(Soldier's Signature) (Date)

SIGNATURE _____

(Counselor's Signature)

Figure 4–3. Sample acknowledgment of notification and counseling

APPENDIX C

GENERAL COUNSELING FORM

For use of this form, see AR 635-200; the proponent agency is MILPERCEN

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: 5 USC 301, 10 USC 3012 (G).
PRINCIPAL PURPOSE: To record counseling data pertaining to service members.
ROUTINE USES: Prerequisite counseling under paragraphs 5-8, 5-13, chapters 11, 13 or section III, chapter 14, AR 635-200. May also be used to document failures of rehabilitation efforts in administrative discharge proceedings.
DISCLOSURE: Disclosure is voluntary, but failure to provide the information may result in recording of a negative counseling session indicative of the subordinate's lack of a desire to solve his or her problems.

PART I - BASIC DATA

1. NAME		3. GRADE	4. SEX
Doe, John Q.	123-45-6789	E4	Male

5. UNIT	*FOR TRAINING UNITS ONLY*	
	6. WEEK OF TRAINING	7. TRAINING SCORES
HHC, 1st Training Brigade		HIGH ____ MED ____ LOW ____

PART II - OBSERVATIONS

8. DATE AND CIRCUMSTANCES

The purpose of this command counseling is to inform you of DA and command policy regarding your responsibilities as a result of testing positive for the Human Immunodeficiency Virus (HIV) antibody. This counseling supplements and complements the preventive medicine counseling you received on 20 FEB 01.

9. DATE AND SUMMARY OF COUNSELING

I have been advised that you were counseled by Preventive Medicine personnel concerning your diagnosis of HIV positivity, the risk this condition poses to your health, as well as the risk you pose to others. You were advised by medical personnel as to necessary precautions you should take to minimize the health risk to others as a result of your condition. While I have great concern for your situation and needs, in my capacity as a commander, I must also be concerned with, and ensure the health, welfare, and morale of the other soldiers in my command. Therefore, I am imposing the following restrictions:

a. You will verbally advise all prospective sexual partners of your diagnosed condition prior to engaging in any sexual intercourse. You are also ordered to use condoms should you engage in sexual intercourse with a partner.

b. You will not donate blood, sperm, tissues, or other organs since this virus can be transmitted via blood and body fluids.

c. You will notify all health care workers of your diagnosed condition if you seek medical or dental treatment, or accident requires treatment. If you do not understand any element of this order, you will address all questions to me. Failure on your part to adhere to your preventive medicine counseling or the counseling I have just given you will subject you to administrative separation and/or punishment under the UCMJ, as I see fit.

DISPOSITION INSTRUCTIONS
This form will be destroyed upon : reassignment (other than rehabilitative transfers), separation at ETS, or upon retirement

APPENDIX D

SAMPLE
COMMANDING OFFICER REQUEST FOR ROUTINE
(NON EMERGENCY) MENTAL HEALTH EVALUATION

Date:

MEMORANDUM FOR COMMANDING OFFICER (Name of Medical Treatment Facility (MTF) or Clinic)

FROM: COMMANDING OFFICER, (Name of Command)

SUBJECT: Command Referral for Mental Health Evaluation of (Service Member Rank, Name, Branch of Service and SSN)

References: (a) DoD Directive 6490.1, "Mental Health Evaluations of Members of the Armed Forces," October 1, 1997
(b) DoD Instruction 6490.4, "Requirements for Mental Health Evaluations of Members of the Armed Forces," August 28, 1997
(c) Section 546 of Public Law 102-484, "National Defense Authorization Act for Fiscal Year 1993," October 1992
(d) DoD Directive 7050.6, "Military Whistleblower Protection," August 12, 1995

(1) In accordance with references (a) through (d), I hereby request a formal mental health evaluation of (rank and name of Service member).

(2) (Name and rank of Service member) has (years) and (months) active duty service and has been assigned to my command since (date). Armed Services Vocational Aptitude Battery (ASVAB) scores upon enlistment were: (list scores). Past average performance marks have ranged from _ ___ _ to _____ (give numerical scores). Legal action is/is not currently pending against the Service member. (If charges are pending, list dates and UCMJ articles). Past legal actions include: (List dates, charges, non judicial punishments (NJPs) and/or findings of Courts Martial.)

(3) I have forwarded to the Service member a memorandum that advises (rank and name of Service member) of his (or her) rights. This memorandum also states the reasons for this referral, the name of the mental health care provider(s) with whom I consulted, and the names and telephone numbers of judge advocates, DoD attorneys and/or Inspectors General who may advise and assist him (or her). A copy of this memorandum is attached for your review.

(4) (Service member's rank and name) has been scheduled for evaluation by (name and rank of metal healthcare provider) at (name of MTF or clinic) on (date) at (time).

SAMPLE
COMMANDING OFFICER REQUEST FOR ROUTINE
(NON EMERGENCY) MENTAL HEALTH EVALUATION, continued

(5) Should you wish additional information, you may contact (name and rank of the designated point of contact) at (telephone number).

(6) Please provide a summary of your findings and recommendations to me as soon as they are available.

(Signature)
Rank and Name of Commanding Officer

Attachment:
As stated

APPENDIX E

SAMPLE
SERVICE MEMBER NOTIFICATION OF COMMANDING OFFICER
REFERRAL FOR MENTAL HEALTH EVALUATION

Date:

MEMORANDUM FOR (Service member's rank, name and SSN)

FROM: COMMANDING OFFICER, (Name of Command)

SUBJECT: Notification of Commanding Officer Referral for Mental Health Evaluation (Non-Emergency)

References: (a) DoD Directive 6490.1, "Mental Health Evaluations of Members of the Armed Forces," October 1, 1997
(b) DoD Instruction 6490.4, "Requirements for Mental Health Evaluations of Members of the Armed Forces," August 28, 1997
(c) Section 546 of Public Law 102-484, "National Defense Authorization Act for Fiscal Year 1993," October 1992
(d) DoD Directive 7050.6, "Military Whistleblower Protection," August 12, 1995

(1) In accordance with references (a) through (d), this memorandum is to inform you that I am referring you for a mental health evaluation.

(2) The following is a description of your behaviors and/or verbal expressions that I considered in determining the need for a mental health evaluation: (Provide dates and a brief factual description of the Service member's actions of concern.)

(3) Before making this referral, I consulted with the following mental health care provider(s) about your recent actions: (list rank, name, corps, branch of each provider consulted) at (name of Medical Treatment Facility (MTF) or clinic) on (date(s)). (Rank(s) and name(s) of mental healthcare provider(s)) concur(s) that this evaluation is warranted and is appropriate.

OR

Consultation with a mental healthcare provider prior to this referral is (was) not possible because (give reason; e.g., geographic isolation from available mental healthcare provider, etc.)

SAMPLE
SERVICE MEMBER NOTIFICATION OF COMMANDING OFFICER
REFERRAL FOR MENTAL HEALTH EVALUATION, continued

(4) Per references (a) and (b), you are entitled to the rights listed below:

a. The right, upon your request, to speak with an attorney who is a member of the Armed Forces or is employed by the Department of Defense who is available for the purpose of advising you of the ways in which you may seek redress should you question this referral.

b. The right to submit to your Service Inspector General or to the Inspector General of the Department of Defense (IG, DoD) for investigation an allegation that your mental health evaluation referral was a reprisal for making or attempting to make a lawful communication to a Member of Congress, any appropriate authority in your chain of command, an IG, or a member of a DoD audit, inspection, investigation or law enforcement organization or in violation of (reference(a)), DoD Instruction (reference (b)) and/or any applicable Service regulations.

c. The right to obtain a second opinion and be evaluated by a mental healthcare provider of your own choosing, at your own expense, if reasonably available. Such an evaluation by an independent mental healthcare provider shall be conducted within a reasonable period of time, usually within 10 business days, and shall not delay nor substitute for an evaluation performed by a DoD mental healthcare provider.

d. The right to communicate without restriction with an IG, attorney, Member of Congress, or others about your referral for a mental health evaluation. This provision does not apply to a communication that is unlawful.

e. The right, except in emergencies, to have at least two business days before the scheduled mental health evaluation to meet with an attorney, IG, chaplain, or other appropriate party. If I believe your situation constitutes an emergency or that your condition appears potentially harmful to your well being and I judge that it is not in your best interest to delay your mental health evaluation for two business days, I shall state my reasons in writing as part of the request for the mental health evaluation.

f. If you are assigned to a naval vessel, deployed or otherwise geographically isolated because of circumstances related to military duties that make compliance with any of the procedures in paragraphs (3) and (4), above, impractical, I shall prepare and give you a copy of the memorandum setting forth the reasons for my inability to comply with these procedures.

(5) You are scheduled to meet with (name and rank of the mental healthcare provider) at (name of MTF or clinic) on (date) at (time).

SAMPLE
SERVICE MEMBER NOTIFICATION OF COMMANDING OFFICER
REFERRAL FOR MENTAL HEALTH EVALUATION, continued

(6) The following authorities can assist you if you wish to question this referral:

a. Military Attorney: (Provide rank, name, location, telephone number and available hours.)

b. Inspector General: (Provide rank/title, name, address, telephone number and available hours for Service and IG, DoD. The IG, DoD number is 1-800-424-9098.)

c. Other available resources: (Provide rank, name corps/title of chaplains or other resources available to counsel and assist the Service member.)

(Signature)
Rank and Name of Commanding Officer

I have read the memorandum above and have been provided a copy.

Service member's signature: _____ Date: _____

OR

The Service member declined to sign this memorandum which includes the Service member's Statement of Rights because (give reason and/or quote Service member).

Witness's signature: _____ Date: _____

Witness's rank and name: _____ Date: _____

(Provide a copy of this memorandum to the Service member.)

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